SCHOOL PSYCHOLOGISTS' RESPONSE TO SELF-INJURIOUS BEHAVIORS OF ADOLESCENTS

by

Courtney L. Runkle

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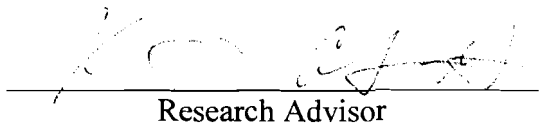

Research Advisor

The Graduate School
University of Wisconsin-Stout
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The Graduate School
University of Wisconsin-Stout
Menomonie, WI 54751

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ABSTRACT

Parents, educators and school staff, medical personnel, and mental health professionals are becoming increasingly aware of the prevalence of self-injurious behavior in today's youth. Research shows that self-injurious behaviors are more prevalent in the adolescent population. As a result, school personnel, school psychologists in particular, are in an ideal position to assist and help the youngsters who engage in self-injurious behaviors. Unfortunately, research on the response to self-injurious behaviors in the school setting is limited at best. Consequently, this research paper will review the literature regarding the nature and characteristics of self-injurious behaviors in the adolescent population. In addition, a method will be proposed for carrying out research that elicits data regarding the school psychologists' response to self-injurious behaviors in the school setting.

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Chapter I: Introduction

Public interest in self-injurious behavior (SIB) has increased in recent years. Specifically, parents, mental health personnel, medical professionals, educators, and other school personnel are concerned with its prevalence, particularly in the adolescent population (Stone & Sias, 2003; White Kress, Gibson, & Reynolds, 2004; White Kress, 2004). Although studies suggest that approximately 13 to 14% of adolescents in the community engage in self-injurious behavior (Hawton, Rodham, Evans, & Weatherall, 2002; Ross & Heath, 2002), what is remarkable is that the occurrence of self-injurious behavior is substantially higher, 61%, in the adolescent clinical population (DiClemente, Ponton, & Hartley, 1991). This latter statistic is further remarkable when contrasted with the general population finding of 4% occurrence rate of self-injurious behaviors (Stone & Sias, 2003).

Self-injurious behaviors have been called many different names in past years by mental health professionals. The three most common names are self-injurious behavior, self-harm, and self-mutilation (Stone & Sias, 2003). For the purposes of this paper, these three terms will be used interchangeably. Self-injurious behavior can be defined as "the commission of deliberate harm to one's own body. The injury is done to oneself, without the aid of another person, and the injury is severe enough for tissue damage such as scarring to result. Acts that are committed with conscious suicidal intent or are associated with sexual arousal are excluded." (Winchel & Stanley, 1991). It should be noted, however, that this is only one definition of self-injurious behavior. As discussed in detail in chapter two, there are numerous definitions of self-injury present in literature, and there is not one generally agreed upon definition amongst professionals and experts.

Even though the focus of this paper will be on self-injury engaged in by individuals who are not developmentally disabled, it is also important to note that self-injurious behavior is also often discussed in regards to those individuals with cognitive disabilities and developmentally disabled populations. The type of self-injurious behavior that individuals with cognitive disabilities most often engage in is head banging or eye pressing. Even though the types of behaviors engaged in, i.e., head banging versus cutting, are different the common aspect is that harm or injury can occur from both. This is important to remember for anyone who engages in self-injurious behavior needs to be treated and protected from themselves if at all possible (White Kress, et al, 2004).

Self-injurious behavior can be divided into two broad categories: culturally sanctioned/approved and deviant self-mutilation (Stone & Sias, 2003). Culturally sanctioned/approved self-mutilation appears in the forms of body or ear piercing, tattooing, and plastic or cosmetic surgery. The focus of this paper, however, will be on the latter form, deviant self-mutilation. Favazza (1996) breaks down deviant self-mutilation into three distinct types: major, stereotypic, and superficial. For a discussion on all three types refer to Favazza (1996). Superficial self-mutilation is briefly described since that type will be the focus of this research paper.

Superficial Self-Mutilation

The most common form of self-mutilation, known as superficial, can be further categorized into three subcategories: compulsive superficial, episodic, and repetitive (Favazza, 1996). Compulsive superficial self-mutilating behavior tends to occur many times a day and is repetitive and ritualistic. Examples of this type are pulling and collecting hair, picking

obsessively at real or imaginary skin lesions and in doing so damaging the tissue enough to leave scars (Stone & Sias, 2003).

Episodic self-mutilation refers to behaviors that occur every so often (Favazza, 1996). Cutting is known to be the most common form of this type of self-injury, followed by burning, self-hitting, interference with wound healing, hair pulling, and bone breaking (Stone & Sias, 2003). In addition, Nock & Prinstein (2004) identified scraping skin to draw blood, biting self, inserting objects under skin or nails, and erasing skin to draw blood as other forms of self-mutilation.

The third subcategory, repetitive self-mutilation, occurs when episodic behavior has become an overwhelming preoccupation, or when the client has developed an identity based upon his or her behavior (Favazza, 1996). For example, these clients may call themselves "cutters." Clients that engage in repetitive self-mutilation describe themselves as being addicted to their self-injurious behavior.

Motivations for self-injurious behaviors are specific to the individual, yet research has found some common characteristics. One frequently self-reported reason for self-injurious behavior is emotional in nature. Specifically, a large majority of respondents in several studies indicated that self-injuring performed some sort of emotional function: controlling or regulating, expressing, or coping with feelings (Cloutier, & Aggarwal, 2002; Levander, 2004). Professional literature has also cited previous sexual and physical abuse, eating disorders, and mental illness as contributing factors to self-injurious behavior (Favazza, & Conterio, 1989; Favazza, DeRosear, & Conterio, 1989; Levander, 2004).

Rationale/Problem

Given the prevalence and incidence of self-injury in the general adolescent population, any given school psychologist will likely come across a student who engages in self-injurious behavior. As a result, a school psychologist is in an opportune position to advocate for those students and provide an appropriate and ethical response to those behaviors. As such, school psychologists who work with adolescents have a professional and ethical responsibility to be well educated and informed regarding the appropriate response to self-injurious behavior in the adolescents they serve.

To properly assist and help adolescents who engage in self-injurious behavior, schools need a well defined, clear set of policies and procedures that dictate the proper course of action that should take place when an individual who engages in self-injurious behavior presents him/herself. Explicit procedures should be followed to ensure equal treatment of all students who present with Self-injurious behaviors, to ensure that ethical and appropriate reporting of the behavior takes place, and that those individuals who need to be notified of the behavior, such as the students' parents, are informed within a timely manner.

Given the growing problem with self-mutilative behaviors in the adolescent population, there is a distinct need for more knowledge and understanding of how school psychologists deal with its occurrence. Purpose of this proposed study is to acquire such an understanding through an examination of the current research regarding self-injury in adolescents, and more specifically, how self-injurious behavior is addressed by school psychologists. The results of the literature review ill then guide an original empirical investigation on the subject.

Purpose

The purpose of this review is to examine self-injurious behavior of adolescents in the school setting. To do so, through examination of the current research of self-injury in adolescents will be done. Specifically, this study aims to gain a more thorough understanding of how school psychologists respond to an individual who engages in self-injurious behavior. What type of procedures do they follow? Is there an official school protocol for addressing self-injurious behavior in students? This investigation into school responses and protocol will be done by attempting to answer the following questions.

1. Are school psychologists trained and/or educated specifically on self-injurious behaviors?
2. What programs, if any, do school psychologists have for adolescents who self-injure?
3. What are the policies, procedures, and protocol schools have adopted to address the issue of self-injury in students?

Definition of Terms

Self-injury - the commission of deliberate harm to one's own body. The injury is done to oneself, without the aid of another person, and the injury is severe enough for tissue damage (such as scarring) to result. Acts that are committed with conscious suicidal intent or are associated with sexual arousal are excluded (Winchel & Stanley, 1991).

Episodic Self-Mutilation – present when self-mutilative behaviors occur in isolation; that is, there is no repetition or pattern to the self-mutilative behavior (Favazza, 1996).

Repetitive Self-Mutilation – present when episodic self-mutilative behavior has become an overwhelming preoccupation, or when the client has developed an identity based upon his or her behavior (Favazza, 1996).

Limitations of the Research

For this investigation, the discussion will be limited to those adolescents in the non-cognitively disabled or developmentally disabled populations. In addition, self-injurious behavior will only be considered in regards to non-lethal intentions. Repeated, unsuccessful suicide attempts will not be considered self-injurious behavior for this investigation. This paper is also limited in that it is a literature review of existing data. No new information will be drawn from the contents of this paper.

Chapter II: Literature Review

Self-injurious behavior, a growing concern of parents, educators, medical personnel, and mental health professionals, has garnered popular media and literature coverage in recent years (Ross & Heath, 2002). The behavior has been referred to by many names including self-injurious behavior, deliberate self-harm, self-mutilation, and delicate self-cutting. Professional literature and scientific research has begun to address Self-injurious behaviors, particularly in the adolescent population (Favazza, 1998). Researchers have focused on several different aspects of the behavior including formulating a definition, the prevalence and incidence in adolescents, common characteristics of the typical self-injurer, motivations and influencing factors, and treatment modalities. In addition, given that self-injurious behavior is most prevalent among adolescents, special attention will be given to self-injurious behavior literature pertaining to the school setting and school psychologists in particular. This chapter will review the literature on the above.

What is Self-Injury?

Varying definitions of self-injurious behavior abound in current research regarding the behavior. The complexity and multidimensional nature of self-injurious behavior lends itself to difficulties in agreeing upon one widely agreed upon definition. Favazza & Conterio (1989) define self-injurious behavior (SIB) as "a complex behavior in which people deliberately alter or destroy their body tissue without conscious suicidal intent, or willingly allow others to alter or destroy their body tissue." A notable aspect of this definition is that allowing another individual to injure the consenting individual's body tissue in someway also constitutes SIB. It can be surmised that the consenting individual is still committing self-injury because it is the self that is allowing another individual to injure their body.

Winchel & Stanley (1991) define SIB "as the commission of deliberate harm to one's own body. The injury is done to oneself, without the aid of another person, and the injury is severe enough for tissue damage such as scarring to result. Acts that are committed with conscious suicidal intent or are associated with sexual arousal are excluded." The definition proposed by these researchers states that SIB must be committed by the individual on which the injury is occurring. The difference between the two proposed definitions is obvious; the former asserts that the injury can be committed by another individual whereas the latter states that the injury must be committed by the same individual.

There are, however, some similarities in the definitions presented. Both definitions focus on the criteria of tissue damage. Also, and more importantly, both definitions assert the behavior must occur without suicidal intent. Support for this criterion is garnered from a study conducted by Muehlenkamp & Gutierrez (2004). Data from 390 high school students were collected to examine potential differences between adolescents who had attempted suicide and those who engaged in SIB. Participants completed the Suicidal Ideation Questionnaire, the Reynolds Adolescent Depression Scale, the Multi-Attitude Suicide Tendency Scale, and the Self-Harmful Behavior Scale. Results indicate that significant differences on attitudes toward life were found between the self-injury and suicide attempt groups.

Still, other definitions exist to describe SIB. Levander (2004) defines self-injury as "the act of attempting to alter a perceived intolerable mood state by inflicting physical harm serious enough to cause tissue damage to the body." This definition is considerably different from the two previous in that it attempts to classify self-injury according to its motivation. Instead of addressing who is engaging in the injury, this author focuses on possible reasons of why it is occurring.

Definitions of SIB consist of similar aspects, such as tissue damage and distinction from attempted suicide. The previously discussed definitions differ with respect to who committed the injury and general focus of the definition. Some definitions focus on who engages in the self-injury and others focus on the motivations behind it.

Prevalence and Incidence

Estimates on the frequency of SIB vary greatly in professional literature and research. Levander (2004) states that current estimates are as little as 1% of the general population engages in SIB. However, for the purposes of this article, a closer look at the prevalence and incidence in the adolescent population is more appropriate. When investigating the frequency within this subpopulation an important distinction is made. Specifically, frequency rates are dramatically different when comparing the general adolescent population with the general adult population.

Ross & Heath (2002) investigated the prevalence of SIB in the general adolescent population. Four hundred forty high school students participated in the study by filling out a self-injury screener entitled "How Do I Deal With Stress," the Beck Depression Inventory, and the Beck Anxiety Inventory. In addition, depending on the how the respondent filled out the self-injury screener, the participants were also interviewed by the researchers. Of the 20.5% (N = 90) of the respondents who indicated that they had hurt themselves on purpose on the self-injury screener, 13.9% (N = 61) could be categorized as having engaged in SIB. Gender differences in the prevalence of self-injury were also examined. Results indicated that of the adolescents who self-injured 64% (N = 39) were females and 36% were males (N = 22).

Hawton, et al, (2002) also investigated the prevalence of Self-injurious behaviors in the general adolescent population. Data from 6,020 students, aged 15 and 16, were collected from

forty-one different schools in England. Participants responded via a self-report questionnaire that elicited demographic data, the occurrence of Self-injurious behaviors, and the factors associated with it. Results from their study indicated that 6.9% (N = 398) of students reported an act of deliberate self-harm in the previous year and 13.2% reported a lifetime history leading the researchers to believe that self-injury in adolescents is common. Additionally, deliberate self-harm was more common in females (11.2%) than males (3.2%).

In comparison to the general adolescent population the research on the prevalence of the *clinical* adolescent population reflects a much higher prevalence rate. DiClemente, et al, (1991) sampled 76 psychiatrically hospitalized adolescents by conducting semi-structured interviews and providing self-report questionnaires for the adolescents to complete. Results from their analysis indicated that 61.2% of the adolescents sampled engaged in SIB.

In summary, the distinction between the general and clinical adolescent populations is important to make based on the findings of the previously discussed research studies. Results indicate that the prevalence rate of self-injury in adolescents range from 13.2% to 13.9% in the general population and is 61.2% in the clinical population.

Common Characteristics: The Typical Self-Injurer

Researchers and professionals have attempted to investigate the profile of the typical individual who engages in SIB. Determining the typical self-injurer can aid in detection and provide parents, educators, medical personnel, and mental health professionals a general idea of what characteristics to assess when working with adolescents.

Favazza & Conterio (1989) conducted extensive research to paint the picture of a typical individual who engages in SIB. In the autumn of 1985 the topic of self-injury was discussed on a national daytime television show and several regional ones on which at least one of the authors

was a guest. Viewers were shown an address to which they could write for information about Self-Abuse Finally Ends (S.A.F.E.), a self-help group for individuals who engage in SIB. The researchers sent each letter writer a questionnaire about self-mutilative practices. A cover letter instructed the individual to either fill out the questionnaire themselves if they considered themselves to be a self-injurer or to pass the questionnaire on to the SIB individual about whom they were concerned. The questionnaire asked subjects to write an essay "about anything that might help us to understand more about your self-harm behavior, your feelings, hopes, and experiences." It also requested demographics, personal and familial information, as well as information about a large number of behavioral, attitudinal, and emotional aspects of self-harm. In all, 240 questionnaires were usable in the analysis.

General results indicated that the average age of subjects was twenty-eight, with a range of fourteen to seventy-one. Ninety-seven percent were Caucasian and the average educational level achieved was one year of college. Half of the respondents were single, one-third married, and 14% divorced.

Results in regards to familial data included the histories of family members with a mental health problem. Respondents indicated that 34% of their fathers and 33% of their mother had "any mental disorder." Additionally, 23% reported that their fathers were alcoholics and 16% reported that their mothers were depressed (Favazza & Conterio, 1989).

More telling was the data on childhood background. More than half (54%) of the subjects selected the adjective 'miserable' to describe their childhood; only 8% selected 'happy.' Childhood abuse was noted by 62% of respondents; 29% reported both physical and sexual abuse and 17% reported only sexual abuse. The average age of onset for sexual abuse was seven years and six years physical abuse (Favazza & Conterio, 1989).

The percentage of subjects who answered true to a series of statements regarding personal attributes was as follows: usually felt empty inside (72%); cannot find words to express feelings (73%); am a burden to others (75%); not understood by anyone (67%); want to stop emotional pain (82%); scared when close to anyone (69%); like attention resulting from self-harm (20%); could always express feelings to family (20%); and always told to be strong (68%) (Favazza & Conterio, 1989).

Information about the mutilative practices indicated that seventy-five percent of subjects utilized multiple methods of self-mutilation. Skin-cutting was the most common at 72% followed by skin-burning (35%), self-hitting (30%), interference with wound healing and severe skin-scratching (22%), hair-pulling (10%), and bone-breaking (8%). The first act of self-mutilation typically occurred at age fourteen as skin-cutting. Ninety-one percent reported that the first incident "just happened" and that someone else usually knew about the behavior (42%). Only 8% sought help within a week after their first self-injurious act, 37% within a year, and 39% did not ever seek help (Favazza & Conterio, 1989).

Half of the sample indicated that they had mutilated themselves more than 50 times, 81% considered their self-mutilation to be an ongoing problem, and 71% consider their SIB to be an addiction. The decision to self-injure is usually made on the spur of the moment (78%) or an hour before the act occurs (15%). Most of the subjects have multiple scars on their arms (74%), legs (44%), abdomen (25%), head (23%), chest (18%), and genitals (8%). Self-injury helps subjects to control their mind when it is racing (72%), feel relaxed (65%), feel less depressed (58%), feel real again (55%), and feel less lonely (47%). In addition, 61% of subjects admitted that they "now have or at some time in the past have had an eating disorder." Fifteen percent

listed their eating disorder as anorexia, 22% as bulimia, 13% as both anorexia and bulimia, and 11% listed marked obesity (Favazza & Conterio, 1989).

To summarize the preceding researching findings, the typical self-injurer is a 28-year-old Caucasian female who first deliberately harmed herself at age 14. Skin cutting is her usual practice, but she has used other methods such as skin-burning and self-hitting, and she has injured herself on at least 50 occasions. Her decision to self-injure is impulsive and results in temporary relief from symptoms such as racing thoughts, depersonalization, and marked anxiety. She now has or has had an eating disorder (Favazza & Conterio, 1989). It should be noted that for the previously discussed study, no specific attempts were made to sample minority populations.

More recently, Nixon, Cloutier, & Aggarwal (2002) addressed the characteristics of self-injury in hospitalized adolescents. Adolescents who were admitted to or were participating in the inpatient and acute youth partial hospitalization programs were screened by staff for recent SIB. Participants were asked to complete a demographic questionnaire, the Ottawa/Queen's Self-Injury Questionnaire, the Beck Depression Inventory, and the State-Trait Anger Expression Inventory. Those with current repetitive SIB of at least once per month during the past six months were included in the analysis for a total of 42 participants.

Of the SIB participants, 85.7% (N = 36) were female. The mean age of participants was 15.7 and the mean age of onset of SIB was 12.7 years. Fifty percent of the respondents reported problems with an eating disorder, 42.9% problems with drugs and/or alcohol, 50% sexual abuse, 45.2% physical abuse, and 61.9% emotional abuse. Approximately 78% of the participants reported almost daily urges to self-injure, with 88.9% of females and 50% of males reporting acts of self-injury to be highly repetitive in nature, occurring from at least once a week to almost

daily. Multiple means of self-injury were utilized including cutting (97.6%), scratching (76.2%), hitting (66.7%), interfering with wounds (50%), hair-pulling (57.1%), biting (54.8%), head-banging (47.6%), nail-biting/injuries and burning (45.2%), piercing body parts (31%), using needles (26.2%), and trying to break bones (14.3%). Participants also reported on the location of the injury on their bodies. Lower arm/wrist injuries occurred in 97.6% of the respondents, upper arm/elbow in 57.1%, lower leg/ankle, in 40.5%, thigh/knee in 38.1%, hand/fingers in 35.7%, and abdomen in 26.2% (Nixon et al, 2002).

Levander (2004) lists several psychological characteristics of individuals who engage in SIB in a presentation packet in which he did an extensive literature review of both empirical research and theory articles. Self-injurers tend to strongly dislike/invalidate themselves, are hypersensitive to rejection, are chronically angry (usually at themselves), tend to suppress their anger, have high levels of aggressive feelings (which they disapprove of strongly and often suppress or direct inward), are more impulsive, tend to act in accordance with their mood of the moment, tend not to plan for the future, are depressed and suicidal/self-destructive, suffer chronic anxiety, tend toward irritability, do not see themselves as skilled at coping, do not have a flexible repertoire of coping skills, do not think they have much control over how/whether they cope with life, tend to be avoidant, and do not see themselves as empowered.

Motivations and Influencing Factors

The motivations behind the occurrence of SIB are as varied and numerous as the individuals who engage in the behavior. Professional literature, both theoretical and empirical, suggests that the motivations behind SIB are primarily affective in nature. In his presentation packet Levander (2004) discussed relief from psychological pain, release of mounting tension, inability to feel, feeling too much, in ability to handle any kind of feeling (good or bad), wanting

to feel something, expressing anger, and attention seeking as possible reasons why individuals engage in SIB.

Ross & Heath (2003) examined the theoretical underpinnings of self-mutilation by addressing two models, the hostility and anxiety reduction models, in a community sample of adolescents. The researchers investigated whether or not adolescents who engaged in SIB reported greater levels of generalized hostility or anxiety when compared to non-self-injurious adolescents, and whether adolescents who self-injure report hostility, anxiety, or both prior to the self-injurious act. Adolescents (N = 122), aged 12 to 16, participated in the study. Students were classified as self-injurious based on their responses on both an initial screening questionnaire and during a semistructured interview. The Hostility and Direction of Hostility Questionnaire (HDHQ) was administered to provide a measure of trait hostility and the Beck Anxiety Inventory was used as a measure of anxiety. Results indicated that adolescents who self-injure scored significantly higher on the following subscales of the HDHQ: self-criticism, criticism of others, delusional guilt, delusional hostility, acting out hostility, extrapunitive hostility, intropunitive hostility, and total hostility. With regards to anxiety, adolescents who engaged in SIB reported significantly higher levels of anxiety than those adolescents who did not engage in SIB. In addition, 54.1% of the adolescents sampled reported feelings of both anxiety and hostility prior to committing the act of self-injury.

Nixon, et al, (2002) also investigated possible reasons behind SIB. Hospitalized adolescents completed self-report questionnaires that addressed reasons of SIB.

Table 1

Most Common Reasons Endorsed for Engaging in Self-Injury

REASON	PERCENTAGE (N = 42)

Cope with feelings of depression	83.3
Release unbearable tension	73.8
Cope with nervousness/fear	71.4
Express frustration	71.4
Express anger/revenge	66.7
Feel pain in one are when other pain I feel is unbearable	61.9
Distraction from unpleasant memories	59.5
Punish self for being bad/bad thought	50.0
Stop suicidal ideation/attempt	47.6
Stop feeling alone and empty	42.9
Have control in a situation	40.5
Stop feeling numb/out of touch	40.5
No known reason/just happens	33.3
Punish self for feeling good	26.2
Other reasons	19.0
Change body image/appearance	16.7
Get care or attention from others	9.5
For excitement	7.1
Belong to a group	2.4

In addition to reasons for engaging in SIB, the researchers investigated the addictive qualities of SIB. Results indicated that 97.6% of the respondents reported the behavior occurred more often and/or the severity of the behavior had increased. Self-injury continued despite the recognition that it was harmful for 95.2%, and reoccurring tension level existed for 85.7% of the respondents when they discontinued the behavior. Self-injurious behavior was upsetting but not enough to stop for 81% and social problems existed for 73.8% of the adolescents. Approximately 74% of the respondents indicated that the frequency and/or intensity had increased to achieve the same effect and 64.3% indicated that the behavior was time-consuming (Nixon, et al, 2002).

Hawton, et al, (2002) investigated factors associated with SIB in a community sample of 6,020 adolescents, aged 15 and 16, by asking them to complete a self-report questionnaire. In females, results indicated that influencing factors were recent self-harm by friends, self-harm by

family members, drug misuse, depression, anxiety, impulsivity, and low self-esteem. In males, the factors were suicidal behavior in friends and family members, drug use, and low self-esteem. Females living with one parent had higher rates of self-harm and the behaviors were more common in students who had been bullied. In addition, students who had reported physical or sexual abuse also had significantly higher rates of self-harm.

Additional influencing factors derived from both theoretical and empirical investigations included eating disorders and other mental health diagnoses. Favazza, Derosear, & Conterio (1989) reported, based on clinical experience, case studies, and conversations with staff members on eating disorders units, that patients with eating disorders (especially bulimics) are at a high risk for self-mutilation. Levander (2004) discusses several mental health conditions in his presentation packet in which SIB is seen. These conditions include borderline personality disorder, mood disorders, eating disorders, obsessive-compulsive disorder, post-traumatic stress disorder, dissociative disorders, anxiety and/or panic disorders, and impulsive control disorder not otherwise specified.

Treatment Modalities

Research on effective treatment modalities and intervention strategies specifically targeting SIB is limited. Much of the current research addresses the behavior as a symptom of another disorder, such as borderline personality disorder (Bauserman, 1998). Crowe & Bunclark (2000) reviewed and summarized numerous treatment methods and implications for SIB. Excessive restrictions, such as locking up all sharp objects in the home, on self-harmers are seldom effective. Restrictions tend to lead to conflict with the patient and an abdication by the patient of responsibility for their own safety. In extreme cases, however, it will be necessary to impose such restrictions to maintain their safety. The use of medication is also discussed in

literature. Antidepressants, particularly fluoxetine, are the most common medication used for individuals who engage in SIB. The goal is to reduce the depressive symptoms and indirectly reduce the SIB.

For the individual patient there are many forms of psychological therapy that have been advocated. Recently, dialectical behavior therapy has been referred to as an effective theoretical orientation upon which to base individual psychotherapy on. Linehan (1993; as cited in Crowe & Bunclark, 2000) encourages the client to develop a strong dependent relationship on the therapist, which may include telephone contact out of hours, but only if self-harm has not just occurred. This is designed to reduce the self-harm risk. This technique is accompanied by a therapeutic method in which there is an encouragement of alternative strategies of coping, including adjusting to life and thinking more positively.

In a theoretical review of the literature, Derouin (2004) asserts that multiple treatment modalities will likely be the most effective when addressing SIB in adolescents. Possible strategies include individual, family, and group counseling, music therapy, assertiveness training, communication skills training, and medication. Treatment should engage the child, family, and trusted primary care and mental health providers. The author stresses the importance of identifying and formulating a plan to decrease stressors within the home and school. Therapy should address the developments of articulation skills and learning alternative ways of expressing needs and feelings. Derouin suggests that group therapies for individuals with self-injury are often recommended because it enhances the development of effective peer relationships and assures adolescents they are not alone in their feelings and experiences.

Inpatient treatment programs are also available. Karen Conterio and Wendy Lader Ph. D. are the founders of the first short-term self-injury treatment program in the country. Their

program, called S.A.F.E. Alternatives (Self-Abuse Finally Ends), founded in 1985, accepts both inpatients and partial hospitalization (day hospital) patients. The program's major emphases are on treating clients with respect and empathy and placing the responsibility for recovery with the client. S.A.F.E. Alternatives is a voluntary program in which the client can decide to end their stay at any time. The program is time limited, and the length of stay is determined before the patient arrives. S.A.F.E. Alternatives considers thirty days ideal, but also realizes it may be more difficult to obtain funding for this length of stay because of insurance companies and managed care companies (Conterio, Lader, & Bloom, 1998). No information regarding the average length of stay was reported.

The program has a S.A.F.E. toolbox, which includes several items. The first is the No-Harm contract, often co-authored by the patient. The contract is signed by the patient and the therapist and states that they understand what is expected of the client, as well as what is expected of the program or therapist. A second tool is the impulse control log where the patient writes down feelings, thoughts, situations, etc. that are related to the thought of injuring themselves. The purpose of the impulse control log is for the client to find a connection between their thoughts, feelings, actions, and reactions. Another useful tool utilized by S.A.F.E. Alternatives is called "the five alternatives." This is a list of five alternatives to self-injuring, including going for a walk, writing in a journal, or working on a creative project. For each client, the list is different and tailored to their individual interests, strengths, and personalities. The fourth tool in the toolbox is the use of writing assignments. There are fifteen writings that each client must complete in a sequential order. These assignments help the client focus on self-awareness, identification of feelings, family/relationship issues, and gender/body issues. (Conterio, et al, 1998).

Warm, Murray, & Fox (2002) report findings from a self-report survey in which individuals who engaged in SIB were asked to indicate who they had consulted for treatment for their self-injury in the past and their level of satisfaction with the various sources of professional treatment. Responses were obtained via a website (N = 243); 205 specified their gender as female, 34 as male, and four did not specify. Results indicated that of the 243 respondents, 73.3% (N = 178) reported that they had sought help/support in the past. The identified sources of help were a counselor (N = 111), doctor (N = 94), nurse (N = 65), psychiatrist (N = 115), psychologist (N = 104), social worker (N = 53), self-harm specialist (N = 18), and voluntary organization (N = 28). Medical personnel were rated as providing the most unsatisfactory support, while self-harm specialists were rated as providing the most satisfactory support.

Implications for School Personnel and School Response to Self-Injury

Research on implications for school psychologists and their response to self-injury is limited. Much of this limited professional literature focuses on the self-injuring individual at school and does not address what protocol school psychologists should follow when they encounter a student who engages in SIB.

Froeschle & Moyer (2004) offer what they term "best practices" for school counselors when identifying and working with students who self-injure. Through their professional experience and consultation, they determined to aid in prevention of self-injury school counselors should: consult with other professionals and refer students out when appropriate, collaborate with another professional since hospitalization may be considered; implement individual and group counseling strategies to assist students with self-injury along with the accompanying issues of self-esteem, grief, loss, divorce, assertiveness training, and/or anger; counselors should instill alternative methods of empowerment while supporting the self-

mutilating person's dignity; create a supportive environment and become a safe haven when negative emotions become too encompassing; educate teachers and staff on the importance of listening and empathizing with students; encourage staff to release students from class to visit with the counselor when negative emotions surface; encourage verbalizations from the individuals who engage in SIB; involve the family of the student when possible; parents should be educated on self-mutilation in order to assess dangerous behavior at home; classroom presentations should include related issues such as drug and alcohol abuse, violence, self-esteem, and possible exposure to diseases; modeling, assertiveness training, and showing appropriate ways to voice negative emotions have all been effective with individuals who self-injure; report suspected child abuse; and notify parents and other appropriate personnel when a student is inflicting bodily harm.

Surprisingly and unfortunately, a thorough evaluation of the SIB literature reveals an overwhelming scarcity of relevant research on schools' responses, and school psychologists' responses, to SIB. Currently, there are no published research studies that describe either how schools or school psychologists respond, nor schools' policies/procedure in regards to individuals who self-injure.

Summary

Currently, there is no single definition of SIB that is agreed upon by all experts and professionals. Definitions presented by researchers and authors vary in whether or not SIB is committed by the individual being harmed, or whether allowing another individual to injure your person is considered self-injury (Favazza & Conterio, 1989; Winchel & Stanley, 1991). In addition, other definitions focus on the reasons behind the behavior defining self-injury as an attempt to change an individual's mood state that is perceived to be intolerable (Levander, 2004).

There is, however, a growing consensus that SIB can be distinguished from attempted or repeated attempts of suicide (Muehlenkamp & Gutierrez, 2004) and SIB in persons with developmental disorders.

Research on the prevalence and incidence of self-injury in the adolescent population indicated that between 13 and 14% of the general adolescent population in English speaking countries engage in SIB (Hawton, et al, 2002; Ross & Heath, 2002). These rates are based on self-report surveys and interviews conducted in schools in the United States and England. Not surprisingly, there is a substantial difference between SIB prevalence rates of adolescents in the general population and adolescents in a clinical population. DiClemente, et al, (1991) found that approximately 61% of the adolescents sampled from a clinical population engaged in SIB.

In one of the pioneering studies into the topic of self-injury, Favazza & Conterio (1989) set out to determine common characteristics of individuals who engage in SIB in a general population sample. As a result of their research, they were able to paint a picture of the typical self-injurer. Their research findings indicated that the typical self-injurer is a 28-year-old female who first deliberately harmed herself at age 14. Skin cutting is her usual practice, but she has used other methods such as skin-burning and self-hitting, and she has injured herself on at least 50 occasions. Her decision to self-injure is impulsive and results in temporary relief from symptoms such as racing thoughts, depersonalization, and marked anxiety. She now has or has had an eating disorder. It should be noted, however, that Favazza & Conterio (1989) did not sample adolescents, and recent research regarding the characteristics of adolescents who engage in SIB has been conducted largely in hospitalized or inpatient settings, thus sampling the clinical adolescent population. Nixon, et al, (2002) sampled hospitalized adolescents and were able to

determine characteristics such as, the presence of an eating disorder, abuse, problems with drugs or alcohol, the method of injury, and the location of the injury.

Much of the research conducted on self-injury involved trying to determine the motivations and reasons behind the behavior in the general adolescent population. The research indicated that the reasons behind self-mutilation are mainly affective in nature. Research shows that between 60 and 83% of hospitalized adolescents report reasons such as to cope with nervousness or fear, cope with feelings of depression, and express anger or revenge (Nixon, et al, 2002).

Influencing factors of SIB include, child physical, sexual, or emotional abuse, presence of current or history of an eating disorder, mental health diagnosis, such as depression, anxiety disorder, borderline personality disorder, posttraumatic stress disorder, or impulsive control disorder, drug or alcohol abuse, and self-injury by family or friends (Favazza & Conterio, 1989; Hawton, et al, 2002; Levander, 2004).

Research on the treatment of SIB is limited. Much of the research on the treatment of SIB is conducted based on the behaviors being a symptom of another disorder, such as borderline personality disorder or depression. In this research, self-mutilation is not the main focus of treatment; rather, the behaviors are treated indirectly through the treatment of a disorder.

Literature reviews on different treatment methods for SIB discuss medication, individual and group therapy, and inpatient settings as possible treatment modalities. Medication is typically used to treat a different prevailing disorder. For example, antidepressants are commonly used with individuals who are depressed and engage in SIB. The hope is that the medication will relieve the depression, and, as a result, reduce the SIB (Crowe & Bunclark, 2000). In terms of individual and group therapy, dialectical behavior therapy has been shown to

be effective in reducing the occurrence of SIB (Linehan, 1993; as cited in Crowe & Bunclark, 2000). Finally, inpatient treatment programs are also an option for the treatment of SIB. Self-Abuse Finally Ends (S.A.F.E.) Alternatives is one such program. The program's major emphases are on treating clients with respect and empathy and placing the responsibility for recovery with the client. The program utilizes No-Harm Contracts, impulse control logs, "the five alternatives," and writing assignments as tools for guiding individuals into controlling their SIB (Conterio, et al, 1998).

Finally, research on how SIB is treated in schools is quite limited. Currently, there are no such articles that address policy or procedure when an individual presents with SIB. With the prevalence of SIB in the general adolescent population between 13 and 14%, it is very likely that school personnel will encounter a student who engages in SIB at some point in time. As a result, it is very important for schools to have clearly defined policy and procedure outlining necessary steps to ensure the safety and well being of that student.

Chapter III: Methodology

The purpose of this proposed study is to collect data regarding a school psychologists' response to SIB in the schools. Specifically of interest is how the response varies as a function of school psychologist and district demographics, school psychologist preparedness, and existence of SIB protocol and procedure. Selection of the participant, instrumentation, data collection procedures, and data analysis will be described in detail. Limitations of the study will also be discussed.

Participants

This proposed study will sample school psychologists from around the United States. Participants will be accessed through the National Association of School Psychologists (NASP) that provides up to 500 labels, free of charge, for research purposes. As such, a sample size of 500 school psychologists is proposed for this study. The labels provided by NASP are a random sampling of school psychologists throughout the country who are members of the organization. The labels obtained from NASP will include school psychologists that function at all levels of education including elementary, middle, and high school. In addition, the labels will include school psychologists employed in all sizes of school districts including urban, suburban, and rural school districts.

Instrumentation

Currently, there are no existing measures that address the purposes of this study. Therefore, a survey will be designed specifically for this proposed study. The survey will consist of many components. A key component is an explicit definition of SIB. By providing a definition of self-injury to the participants, there is great insurance that all participants are reporting on the same phenomenon.

The first section of the survey will elicit demographic data about the school psychologist participant completing the survey. Examples include the number of years as a school psychologist, number of years at current job/in current school, type of terminal degree, and numbers of students they work with and for whom they are responsible for will all be addressed in the first section.

The second section of the survey will obtain data about the district in which the school psychologist is employed. It is likely that a portion of the participants will be employed by or service more than one school district. In this case, the participant will be prompted to complete the survey regarding the district in which they are responsible for a greater number of students, i.e., the district in which their caseload is greatest. Data concerning the district's size, socioeconomic status, racial/ethnic distribution, and urban/suburban/rural status will be addressed.

The third section of the survey will target the main purpose for this proposed study, the participants' response to self-injury. This section will be bulk of the survey and will elicit data from the participant in a couple different response formats. The participant will be asked to provide information regarding the frequency in which they are confronted with an individual who self-injures. Participants will be asked to report on the number of cases of self-injury that they have seen within the last calendar year and the percentage of professional time spent addressing SIB. The participants will be asked to provide the following information regarding their typical encounter with an individual who engages in SIB: sex, race, and socioeconomic status.

This section will also include an item in which the participants will be asked to provide a brief description of what they typically do in response to SIB. Participants will then be asked to

check which of the following responses they typically use when they have encountered an individual who engages in self-injury: call parents, refer to/provide counseling within the school setting, alert student's teachers, report to social services, refer to outpatient services, refer to inpatient/hospitalization services, and other. Finally, this section will obtain data regarding any atypical responses that they have made to SIB in which the participant will be asked to list those responses.

The fourth section of the survey will obtain data about how prepared the participant feels in handling a case of SIB. Participants will be asked to indicate via a written response their previous experiences, education, and trainings regarding SIB. The participants will also be asked to check which of the following methods of training they have received on self-injury: seminars/workshops, graduate courses, personal research, sessions at professional conventions, and other.

The final area addressed in the survey will be whether or not the participants' school district has an outlined protocol or procedure in which they are to follow when they are presented with an individual who engages in SIB. If the district does have a protocol, the participant will be asked to very briefly describe it.

Data Collection Procedures

Data will be collected via mail. The participant will receive a packet in the mail that includes an informed consent form, the survey, and a self-addressed envelope. Each packet will be assigned a participant identification number. Upon receipt of the packet, the researcher will immediately separate the informed consent form and the survey. These two forms will be stored separately in a secure location so that anonymity and confidentiality are maintained. After three

weeks have passed, a reminder post card will be sent to each participant who has not yet returned a completed survey.

Data Analysis

This proposed study is exploratory in nature in that there are no predetermined hypotheses that will be tested. The data obtained from this proposed study will be largely descriptive because the purpose is to better understand a school psychologists' response to self-injury. However, parametric statistical tests for comparisons across groups and/or correlations between demographic data, and responses to self-injury questions will be used. In addition, all attempts to limit family-wise error rate will be made.

Limitations

Limitations in the methodology of this study are minimal, but are important to discuss. To begin, mailed self-report measures are notorious for producing low-response rates. This could create statistical difficulties when trying to obtain an adequate number of useable surveys that would result in enough power to obtain statically significant results.

A second limitation is also found in the nature of a self-report measure. Self-report measures are highly susceptible to response bias and dishonesty. Participants may respond according to how they think they should respond to self-injury rather in how they actually do respond to self-injury. However, this limitation is minimized as a result of the measures taken to ensure confidentiality and anonymity of participants' responses. Additionally, the participants will not be held to any personal consequences for participating in this study.

Finally, there is no existing measure that addresses a school psychologists' response to self-injury. The instrument will be designed specifically for this proposed study. As a result, there will be no existing data regarding the reliability and validity of the measure. In general, it

is very difficult to create a statistically sound measure. In an attempt to reduce the effects of this limitation, a pilot study will be conducted to determine the above psychometrics. Beta testing will completed to assess the statistical soundness of the measure prior to the proposed study being conducted.

Conclusion

Self-injurious behavior among the adolescent population are becoming a more recognized issue in adolescents. As a result of the prevalence of these behaviors in adolescents, SIB is becoming a more prominent issue in the educational setting. These behaviors represent a mental health problem in which school personnel are being increasingly relied upon to address in the school setting.

Yet, very little is known regarding how school psychologists address SIB in the students they serve. As a result, there is a distinct need for more information regarding the response to SIB that school psychologists engage in to assist and help these youths. This paper reviewed the literature pertaining to SIB in educational settings and the adolescent population. In addition, it proposed a methodology that would elicit information regarding the school psychologists' response to SIB in the schools. The goal of this research was to study the literature related to SIB in the adolescent population and obtain data about how school psychologists respond to SIB when presented with them in the school setting. Obtaining such information will serve to educate other professionals about the prevalence of the problem as well as the strategies or actions that school psychologists use when assisting self-injuring youths. Finally, there is hope that this research will serve as a catalyst in focusing further research and policy attention on this issue, ultimately leading to enhanced functioning for individuals who engage in SIB.

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